

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08528

## CERTIFICATE OF DEATH

Reg. Dist. No.

08532

1. PLACE OF DEATH a. COUNTY <b>CARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XO CRELLIN</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>CARRETT COUNTY MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ARTHUR</b> Middle <b>LYNN</b> Last <b>BOWMAN</b>			4. DATE OF DEATH Month <b>AUGUST</b> Day <b>11</b> Year <b>19 57</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/10/57</b>		9. AGE (In years last birthday) yrs. <b>40</b> Min. <b>13</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>CLARENCE EDWARD BOWMAN, JR.</b>				14. MOTHER'S MAIDEN NAME <b>VIRGINIA MAY HOSE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>CLARENCE EDWARD BOWMAN, JR., CRELLIN, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Hyaline Membrane</b> <b>527.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10 Aug</b> , 19 <b>57</b> , to <b>11 Aug</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11 Aug</b> , 19 <b>57</b> , and that death occurred at <b>10:55 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Oakland Md</b> DATE SIGNED <b>12 Aug 57</b> ACTUAL SIGNATURE <b>A. E. Mance</b> M.D. <b>Oakland Md</b> PHYSICIAN'S NAME (Type) <b>ANDREW E. MANCE M.D.</b> <b>OAKLAND, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 14, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ashby Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crellin, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.R. Watson</b>				ADDRESS <b>Terra Alta, W.Va.</b>		24a. REC'D BY REGISTRAR <b>8/14/57</b> 24b. REGISTRAR'S SIGNATURE <b>Julius M. Brown</b>	

2070192 XV3

CERTIFICATE OF DEATH

BUREAU V. S.

AUG 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08529

## CERTIFICATE OF DEATH

Reg. Dist. No. 08533

1. PLACE OF DEATH a. COUNTY <b>Garrett County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Accident</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing 01X0-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>Watercliffe Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Graham</b> Last <b>Boyd</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>14th.</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 19th. 1874</b>
9. AGE (In years last birthday) <b>83<sup>yr.</sup></b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired School Teacher</b>	
11. BIRTHPLACE (State or foreign country) <b>Lonaconing, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John M. Boyd</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Spears</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mrs. Melvin Kesner, Accident, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Heart Disease</b> <b>420.1</b> DUE TO <b>Left Ventricular Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis - advanced - general</b> DUE TO (c) <b>25 yrs. after</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs. 10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Possible Gastrointestinal malignancy</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/12/57</b> , 19 <b>57</b> , to <b>8/14/57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>8/14/57</b> , 19 <b>57</b> , and that death occurred at <b>7:40 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>48 BROADWAY</b> DATE SIGNED <b>Frederick</b>			
ACTUAL SIGNATURE <b>MARTIN M. ROTHSTEIN M.D.</b> <b>FREESTBURG - MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 16, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lonaconing, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN, LONA CONING? MD.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 27 '57</b>	
24b. REGISTRAR'S SIGNATURE <b>Frederick</b>			

CERTIFICATE OF DEATH

Name of Deceased		Sex	
Age		Date of Birth	
Place of Birth		Usual Residence	
Cause of Death		Date of Death	
Place of Death		Signature of Physician	
Signature of Registrar		Date of Registration	

RECEIVED

AUG 19 1957,  
GARRETT COUNTY  
HEALTH DEPT

RECEIVED  
AUG 27 1957  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 08530 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08534

Reg. Dist. No. 166

1. PLACE OF DEATH o. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>W. VA</b> b. COUNTY <b>PRESTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TERRA ALTA 85X-3</b> ✓			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>RT 4</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>EARL LESLIE FREELAND</b>				4. DATE OF DEATH Month Day Year <b>AUGUST 3 1957</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr 4-1885</b>	9. AGE (In years last birthday) <b>72</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>W. VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES W. FREELAND</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH BRAHAM</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>234-32-8195</b>		17. INFORMANT Address <b>WARDEN FREELAND - YOUNGSTOWN OHIO</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CROSSING INJURIES FACE, SKULL &amp; CHEST</b> <b>802X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>WITH RUPTURED LUNGS</b> DUE TO (c) <b>INSTANT</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture Rt Knee - Left Ankle</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>STRUCK BY RR. LOCOMOTIVE</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>7:15</b> a.m. <b>8/3</b> 19 <b>57</b> p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>RR. CROSSING</b>		20f. (City or town) (County) (State) <b>PRESTON OAKLAND GARRETT MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>E. I. BAUMGARTNER</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>E. I. BAUMGARTNER</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>8/6/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Terra Alta</b>		22d. LOCATION (City, town, or county) (State) <b>Terra Alta Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emerson Golden Oakland Md</b>				24a. REC'D BY REGISTRAR <b>8/6/57</b>		24b. REGISTRAR'S SIGNATURE <b>John C. Kewen</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 18A3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

AUG 14 1957

RECEIVED

08531

## CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Star Route</b>				c. LENGTH OF STAY IN 1b <b>8 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Happy Hills Farm</b>				e. STREET ADDRESS <b>29 Frostburg Ave.</b>			
3. NAME OF DECEASED (Type or print) <b>JACOB</b> First <b>HAFER</b> Middle Last				4. DATE OF DEATH Month <b>8</b> Day <b>8</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 22, 1866</b>	9. AGE (In years last birthday) <b>91</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Furniture &amp; Funeral</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own business</b>		11. BIRTHPLACE (State or foreign country) <b>New Morchen, Germany</b>	
13. FATHER'S NAME <b>Jacob Hafer</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Berg</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Frank A. Mattingly, Frostburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic Cardio -</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Vascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-15-50</b> to <b>8-8</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>8-8</b> , 19 <b>57</b> , and that death occurred at <b>69</b> , M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H.C. Diehl</b>		M.D. <b>39 W. Main St.</b>		ADDRESS (Street, city or town, state) <b>Frostburg, Md.</b>		DATE SIGNED <b>8/9/57</b>	
PHYSICIAN'S NAME (Type) <b>H.C. Diehl, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-10-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park Frostburg</b>		22d. LOCATION (City, town, or county) (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hafer Funeral Home</b>				24a. REC'D BY REGISTRAR <b>8-9-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mrs. Mattingly</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

BURKAY V. S.

AUG 12 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08532

## CERTIFICATE OF DEATH

Reg. Dist. No. 08536  
166

1. PLACE OF DEATH COUNTY <u>Garrett</u> STATE <u>MARYLAND</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Garrett</u> LENGTH OF STAY (In this place) <u>6 wks</u> TOWN <u>Garrett</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Garrett</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Garrett</u> TOWN <u>Kitzmiller</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Evans Nursing Home</u>				STREET ADDRESS (If rural give location) <u>W. Main Street</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Edward Jackson Hamill</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>August 25 1957</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>August 8, 1865</u>	9. AGE last birthday <u>92</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired - Cashier</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Bank</u>		11. BIRTHPLACE (State or foreign country) <u>Kitzmiller, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Henry Hamill</u>				14. MOTHER'S MAIDEN NAME <u>Julia Ann Fazenbaker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Gladys B. Hamill-Kitzmiller, Md.</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
442X IMMEDIATE CAUSE (A) <u>Acute Myocardial Infarction</u>						<u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>chronic condition - Venous Thrombosis</u>						<u>7 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Myocardial infarction</u>						<u>2 weeks</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 19 50</u> , to <u>Aug 25, 1957</u> , that I last saw the deceased alive on <u>Aug 24, 1957</u> , and that death occurred at <u>4:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Ralph Colaninella</u>		M.D. <u>Kitzmiller, Md.</u>		ADDRESS (Street, city, town, state) <u>Blaine, W.Va.</u>		DATE SIGNED <u>Aug 26-57</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Aug. 28/57</u>		NAME OF CEMETERY OR CREMATORY <u>Hamill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Kitzmiller, Md.</u>	
24. REC'D BY REGISTRAR <u>7/26/57</u>		REGISTRAR'S SIGNATURE <u>John C. Rowley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>O. F. Sharpless</u>		ADDRESS <u>Blaine, W.Va.</u>	

# CERTIFICATE OF DEATH

See also No.

1. Name of deceased: *John Doe*

2. Date of death: *August 28, 1957*

3. Place of death: *Home*

4. Cause of death: *Heart Disease*

5. Age at death: *65*

6. Sex: *Male*

7. Race: *White*

8. Signature of physician: *James H. Smith*

9. Signature of registrar: *John Doe*

10. Signature of undertaker: *John Doe*

11. Signature of coroner: *John Doe*

12. Signature of health officer: *John Doe*

13. Signature of medical examiner: *John Doe*

14. Signature of funeral home: *John Doe*

15. Signature of cemetery: *John Doe*

16. Signature of burial place: *John Doe*

17. Signature of interment: *John Doe*

BUREAU V. 3

AUG 28 1957

RECEIVED

08533

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crellin</b>		c. LENGTH OF STAY IN 1b <b>25 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crellin, Maryland</b>	
3. NAME OF DECEASED (Type or print) First <b>Iva</b> Middle <b>Harrett</b> Last <b>Hayes</b>		4. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 13, 1888</b>
9. AGE (In years last birthday) <b>69</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>1</b> Days <b>9</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Tunnelton, West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Newton Michaels</b>		14. MOTHER'S MAIDEN NAME <b>Sara Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>J. W. Hayes,</b>		Address <b>Crellin, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerosis</b> <b>45</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>86 years</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>16 April, 1949</b> to <b>24 Aug 1957</b> , that I last saw the deceased alive on <b>24 Aug 1957</b> , and that death occurred at <b>4:20 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Andrew E. Mance</b>		DATE SIGNED <b>25 Aug 57</b>	
PHYSICIAN'S NAME (Type) <b>ANDREW E. MANCE</b>		ADDRESS (Street, city or town, state) <b>Oakland, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 27, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Shay's Chapel Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Tunnelton, West Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>P. R. Watson</b>		ADDRESS <b>Terra Alta, W. Va.</b>	
24a. RECEIVED BY REGISTRAR <b>8/24/57</b>		24b. REGISTRAR'S SIGNATURE <b>John R. Hovener</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 28 1957

RECEIVED

## CERTIFICATE OF DEATH

08534

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>GARRETT</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>RURAL ACCIDENT</u>		<u>LIFE</u>		TOWN <u>RURAL ACCIDENT</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
1							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JOHN</u> (Middle) <u>CALVIN</u> (Last) <u>HETRICK</u>				(Month) <u>Aug</u> (Day) <u>5</u> (Year) <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>APRIL 6, 1877</u>	9. AGE last birthday <u>80</u> yrs	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>GARRETT Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JOHN C HETRICK</u>				14. MOTHER'S MAIDEN NAME <u>LAURA KIMMET</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Perlando Hetrick, Accident MD</u>			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Heart disease, myocardial infarct</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>				<u>10 yr</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>Aug 5 1957</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 5</u> , 19 <u>57</u> , to <u>Aug 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 5</u> , 19 <u>57</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Don Runkel MD</u>		M.D. <u>Myersville, Pa</u>		DATE SIGNED <u>8/6/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>8/8/57</u>		NAME OF CEMETERY OR CREMATORY <u>ST JOHN'S CODE</u>		LOCATION (City, town, or county) (State) <u>Accident, GARRETT Co, MD</u>	
24. REC'D BY REGISTRAR <u>AUG 13 57</u>		REGISTRAR'S SIGNATURE <u>Don Runkel</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Donald J Newman</u>		ADDRESS <u>Stantwell, Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within 24 hours after death. The both copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 08535 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08539 6

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Near) Oakland</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Eugene Clement Jeffries</b>				4. DATE OF DEATH Month Day Year <b>Aug. 25th. 1957 19</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 5th. 1936</b>	9. AGE (In years last birthday) <b>21 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Frostburg, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clement Jeffries</b>				14. MOTHER'S MAIDEN NAME <b>Margaret McKenzie</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-34-1780</b>		17. INFORMANT <b>Mrs. Eugene Jeffries, Frostburg, MD</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> DOX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Boat Capsized and Sunk.</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>8:25 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>LAKE</b>		20f. (City or town) (County) (State) <b>NR. OAKLAND GARRETT TND.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JAMES H. FEASTER, JR. M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Acting</b>			
22a. BURIAL, CREMATION, or other disposition <b>Burial</b>		22b. DATE THEREOF <b>Aug. 28. 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>				ADDRESS <b>Lonaconing, MD.</b>		24a. RECEIVED BY REGISTRAR DATE <b>9/28/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>John A. [Signature]</b>		DATE SIGNED <b>8-25-57</b>	

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SEP 1957  
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HEALTH DEPT.  
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08536

CERTIFICATE OF DEATH

Reg. Dist. No.

166

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Lake Park,</b>				c. LENGTH OF STAY IN 1b <b>2 Months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kiser Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ada</b> Middle <b>Vernon</b> Last <b>Leighton</b>				4. DATE OF DEATH Month <b>August</b> Day <b>20,</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 17, 1874</b>		9. AGE (In years last birthday) yrs <b>82</b>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Keeper</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>for others</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Isaac c Leighton</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Vernon</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Grace Falkenstein</b> Address <b>Oakland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial infarction</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Hypertensive Arteriosclerotic CVD with 8 years</b> (c) <b>Hypertrophy</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>15 May, 1953</b> , to <b>20 Aug, 1957</b> , that I last saw the deceased alive on <b>16 Aug, 1957</b> , and that death occurred at <b>8:15A. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. E. Mance</b> M.D. <b>101 Third St.</b>				ADDRESS (Street, city or town, state) <b>Oakland, Md.</b> DATE SIGNED <b>22 Aug 1957</b>			
PHYSICIAN'S NAME (Type) <b>A. E. Mance, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/22/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oakland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert C. Leighton</b>				ADDRESS <b>Oakland, Md.</b>		24a. RECEIVED BY REGISTRAR <b>22/57</b> 24b. REGISTRAR'S SIGNATURE <b>Julius C. Brown</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08537

## CERTIFICATE OF DEATH

08541

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL OAKLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X RURAL OAKLAND</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>GRACE</b> Middle <b>I</b> Last <b>LEWIS.</b>				4. DATE OF DEATH Month <b>AUG -</b> Day <b>6</b> Year <b>1957</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov - 20 - 1892</b>	
9. AGE (In years last birthday) <b>65</b> yrs		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>19</b> Hours <b>57</b>		11. BIRTHPLACE (State or foreign country) <b>SWALLOW FALLS MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>ESAREL SPIKER</b>				14. MOTHER'S MAIDEN NAME <b>BENNY SINES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>RICHARD A. LEWIS Rt-1 OAKLAND MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO (c) <b>Season</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>8 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>6 Nov., 1948</b> , to <b>6 Aug., 1957</b> , that I last saw the deceased alive on <b>2 August, 1957</b> , and that death occurred at <b>5:30 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Oakland Md</b> DATE SIGNED <b>8 Aug '57</b> ACTUAL SIGNATURE <b>A. E. France M.D.</b> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>AUG - 9 - 1957</b>		<b>SINES CEMETERY</b>		<b>NEAR OAKLAND MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emroy Bolden</b>				ADDRESS <b>OAKLAND MD</b>		24a. REC'D BY REGISTRAR DATE <b>8/9/57</b>	
24b. REGISTRAR'S SIGNATURE <b>John A. Howard</b>							

BUREAU V. S.

AUG 14 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08538

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08542

Reg. Dist. No. / 66

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS ROUTE #1			
3. NAME OF DECEASED (Type or print) First Middle Last RANDALL EUGENE LOWDERMILK				4. DATE OF DEATH Month Day Year AUGUST 14 19 57			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/8/39		9. AGE (In years last birthday) 17 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY Fathers Farm		11. BIRTHPLACE (State or foreign country) FRIENDSVILLE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROBERT E. LOWDERMILK				14. MOTHER'S MAIDEN NAME AMANDA VAN SICKLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address R. E. Lowdermilk R. D. Friendsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sublethal Hemorrhage DUE TO (b) Comp - Commenced fract. left arm DUE TO (c) Centurion 2 lungs cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile turned over					
20c. TIME OF INJURY Month, Day, Year 5:15 a.m. 8/11 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State road near Friendsville Garrett Co		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE E. I. Baumgartner				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) E. I. BAUMGARTNER, M. D.				8/15/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/17/1957		22c. NAME OF CEMETERY OR CREMATORY Blooming Rose Cemetery		22d. LOCATION (City, town, or county) (State) Near Friendsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Herbert C. Leighton Oakland, Md.				24a. REC'D BY REGISTRAR DATE 8/15/57		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, to burial, cremation, or removal.

RECEIVED

1967

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08539

## CERTIFICATE OF DEATH

Reg. Dist. No.

085436

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institutions Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>/</b>			
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Ples</b> Last <b>Mance</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>5</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 9, 1882</b>		9. AGE (In years last birthday) <b>74 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Croatia, Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Mija Ples</b>				14. MOTHER'S MAIDEN NAME <b>Babara Yakin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Dr. A. E. Mance, Oakland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Chronic Obstructive Pulmonary Disease</b> DUE TO <b>Pneumonia</b> (c) <b>Pneumonia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>2 1/2 yrs</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1945</b> to <b>3 Aug</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>5 Aug</b> , 19 <b>57</b> , and that death occurred at <b>9:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. E. Mance</b> M.D.				ADDRESS (Street, city or town, state) <b>Oakland Md</b> DATE SIGNED <b>8 Aug 57</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/7/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oakland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emory Bolden</b>				ADDRESS <b>Oakland, Md.</b>		24a. RECEIVED BY REGISTRAR <b>FILED</b> 24b. REGISTRAR'S SIGNATURE <b>TR</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 17 1957

RECEIVED

08540

## CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND Balto. 10 MD 3V114</b>	
c. LENGTH OF STAY IN 1b <b>2 MONTHS</b>		d. STREET ADDRESS <b>1302 Roland Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WEEKS NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>TACY WALKER ROBINSON</b>		4. DATE OF DEATH Month Day Year <b>Acc. 10 1957</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY-5-1872</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WILMINGTON OHIO</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>ABE. WALKER.</b>		14. MOTHER'S MAIDEN NAME <b>MARY JANE PATTERSON.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Address <b>MRS. WILSON K. LEVERING JR. 4302 ROLAND AVE. BALTO. MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b> <b>251X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIO SCLEROSIS</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>fracture of Rt. Femur - 1956</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 5, 1956</b> to <b>August 10, 1957</b> , that I last saw the deceased alive on <b>August 10, 1957</b> , and that death occurred at <b>10:20 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. I. Baumgartner</b> M.D.		ADDRESS (Street, city or town, state) <b>25 Alder St Oakland Md</b> DATE SIGNED <b>8/10/57</b>	
PHYSICIAN'S NAME (Type) <b>E. I. BAUMGARTNER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>AUG-12-1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>SUGAR GROVE CEMETERY WILMINGTON OHIO.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emory Bolden</b> ADDRESS <b>OAKLAND MD</b>		24a. RECEIVED BY REGISTRAR DATE <b>8/10/57</b> 24b. REGISTRAR'S SIGNATURE <b>John C. Rowan</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU V. S.

NOV 17 1917

RECEIVED

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08541

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>				c. LENGTH OF STAY IN 1b <b>5 HRS. 15 MIN</b> <b>X</b> / <b>RURAL</b> <b>OAKLAND</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FANNIE</b> Middle <b>Elliott</b> Last <b>SMOUSE</b>			4. DATE OF DEATH Month <b>AUGUST</b> Day <b>12</b> Year <b>1957</b>				
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 20, 1888</b>		9. AGE (In years last birthday) <b>69</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>ADAM ELLIOTT</b>				14. MOTHER'S MAIDEN NAME <b>MARTHA PAUGH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>DANIEL SMOUSE</b> Address <b>ROUTE 2, OAKLAND, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, Acute</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Years</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>JAN. 1949</b> , to <b>AUG. 12, 1957</b> , that I last saw the deceased alive on <b>AUG. 12, 1957</b> , and that death occurred at <b>7:50 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b> M.D. <b>58 2nd St. Oakland, Md</b>				DATE SIGNED <b>8-13-57</b>			
PHYSICIAN'S NAME (Type) <b>JAMES H. FEASTER, JR. M. D. OAKLAND, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/15/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oakland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert C. Leighton</b> ADDRESS <b>Oakland, Md.</b>				24a. REC'D BY REGISTRAR <b>8/15/57</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08542 CERTIFICATE OF DEATH

Reg. Dist. No.

08546

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Res. den. before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DEER PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DEER PARK</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BOWSER NURSING HOME</b>		e. STREET ADDRESS  • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>SILAS</b> Last <b>TEETS</b>		4. DATE OF DEATH Month <b>AUG</b> Day <b>25</b> Year <b>1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE-13-1881</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BLACKSMITH</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ACCIDENT MD</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>SILAS TEETS.</b>		14. MOTHER'S MAIDEN NAME <b>HANNAH SHOYER.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-03-1288</b>	
17. INFORMANT <b>JOSIE TEETS</b>		Address <b>BLOOMINGTON MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Hemorrhage with its sequelae</b> DUE TO (c) <b>Chronic Cor. V. Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>5 days</b> <b>5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan</b> , 1957, to <b>Aug 25</b> , 1957, that I last saw the deceased alive on <b>Aug 24</b> , 1957, and that death occurred at <b>3:50 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Kitzbiller, Md</b> DATE SIGNED <b>Aug 27-57</b> ACTUAL SIGNATURE <b>Ralph C. Landrella</b> M.D. PHYSICIAN'S NAME (Type) <b>Ralph C. Landrella</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>AUG-28-1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>GEORGE CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>NEAR SWANTON MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emory Bolden</b>		24a. REC'D BY REGISTRAR <b>OAKLAND MD</b>	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 21 1957

BUREAU V. S.

08543

## CERTIFICATE OF DEATH

Reg. Dist. No.

166

1. PLACE OF DEATH a. COUNTY <b>Garrett Co.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegheny</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>18 mo.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Week's Nursing Home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
3. NAME OF DECEASED (Type or print) First <b>ALVINA</b> Middle <b>TEUFEL</b> Last <b>TEUFEL</b>		4. DATE OF DEATH Month <b>8</b> Day <b>13</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 5, 1869</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR: Months <b>8</b> Days <b>13</b> Hours <b>19</b> Min <b>57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Brandt</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Harry W. Schmidt</b>		Address <b>814 Camden Ave. Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> 4 <b>min</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Degenerative Cardiovascular Disease</b> DUE TO (c) <b>10 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized bodily debility</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 12, 1957</b> , to <b>Aug. 13, 1957</b> , that I last saw the deceased alive on <b>Aug. 12, 1957</b> , and that death occurred at <b>6:40 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Herbert H. Lighton</b> M.D.		ADDRESS (Street, city or town, state) <b>77 Oak Street, Oakland, Maryland</b>	
DATE SIGNED <b>13 Aug 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 15, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein, Inc.</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>8/14/57</b>		24b. REGISTRAR'S SIGNATURE <b>John C. Royer</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. S.

AUG 11 1911

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08544

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0854866

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON 47X-3</b>			
c. LENGTH OF STAY IN TB <b>3 weeks</b>				d. STREET ADDRESS <b>1211 13th STREET N.W.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JESSIE</b> Middle <b>CONNEMAY</b> Last <b>THRASHER</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>7</b> Year <b>19 57</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>aug 18. 1884</b>	
9. AGE (In years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b>		IF UNDER 24 HRS. Hours <b>57</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk - Int. Rev. Serv. U.S. Government</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>			
11. BIRTHPLACE (State or foreign country) <b>UNITED STATES</b>				12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
13. FATHER'S NAME <b>CONNEMAY, DAVID L.</b>				14. MOTHER'S MAIDEN NAME <b>ASHBY, ELIZA JANE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mrs. J. A. Duffy</b>		Address <b>Oakland, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> 823X DUE TO <b>Fracture left tibia - laceration leg</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Fracture mandible - Fractures 6, 7, 8, 9 Ribs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture mandible - Fractures 6, 7, 8, 9 Ribs</b> INTERVAL BETWEEN ONSET AND DEATH <b>15 m</b> <b>22 days</b>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile accident - Ran over curb</b>					
20c. TIME OF INJURY Month, Day, Year <b>July 16 19 57</b> Hour <b>5</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>State road near Kirkmiller Street</b>		20f. (City or town) (County) (State) <b>Oakland Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <b>E. I. BAUMCARTNER</b>				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>E. I. BAUMCARTNER M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, RITUAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/11/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oakland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert C. Leighton</b>				ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR <b>8/10/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>John A. Howard</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

AUG 14 1957

BUREAU V. S.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN lb <b>1 Day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westernport</b> <b>0143.2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Weeks Nursing Home</b>				d. STREET ADDRESS <b>131 Front St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marie Bridgett Williams</b> First Middle Last				4. DATE OF DEATH Month <b>Aug</b> Day <b>30</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 3, 1881</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min.		11. IF UNDER 24 HRS. Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min.		12. IF UNDER 24 HRS. Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Luke Kearney</b>			
14. MOTHER'S MAIDEN NAME <b>not known</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>no</b>				17. INFORMANT <b>Mrs. Joseph Taylor-Westernport, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis and Myocardial Degeneration not specified as Rheumatic</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>518.0</b> DUE TO (c) <b>518.0</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>518.0</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <b>9</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 27, 1957</b> to <b>Aug. 30, 1957</b> , that I last saw the deceased alive on <b>Aug. 29, 1957</b> , and that death occurred at <b>4:10 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Piedmont, W. Va.</b> DATE SIGNED <b>8-31-57</b> ACTUAL SIGNATURE <b>Paul A. Nelson</b> M.D. <b>Piedmont, W. Va.</b> PHYSICIAN'S NAME (Type) <b>Paul A. Nelson</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/3/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Westernport Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>El. B. B. B.</b>				24a. RECEIVED BY REGISTRAR DATE <b>9/3/57</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. H.</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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